RICHARD B. WOLF, SB# 046173
E-Mail: rwolf@lbbslaw.com
ELISE D. KLEIN, SB# 111712
E-Mail: klein@lbbslaw.com
JANELLE F. GARCHIE, SB# 118453
E-Mail: garchie@lbbslaw.com
KRISTIN P. KYLE de BAUTISTA, SB# 221750
E-Mail: kyledebautista@lbbslaw.com
LEWIS BRISBOIS BISGAARD & SMITH LLP
650 West "C" Street, Suite 800
San Diego, California 92101
Telephone: (619) 233-1006
Facsimile: (619) 233-8627

Attorneys for HEALTH NET OF CALIFORNIA, INC.

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

FREDA SUSSMAN, Plaintiff, v. ARMELIA SANI, M.D., SHILEY EYE CENTER, UCSD MEDICAL CENTER, REGENTS OF THE UNIVERSITY OF CALIFORNIA, HEALTH NET, INC., HEALTH NET SENIORITY PLUS, LINDA BEACH, HAIDEE GUTIERREZ, and DOES 1 through 40, inclusive, Defendants.	CASE NO. 08 CV 0392 H BLM Honorable Marilyn L. Huff Action Removed: March 3, 2008 **DEFENDANT HEALTH NET OF CALIFORNIA, INC.'S OPPOSITION TO PLAINTIFF'S MOTION TO REMAND CASE TO STATE COURT** DATE: April 21, 2008 TIME: 10:30 a.m. CTRM: 13

Defendant Health Net of California, Inc. hereby submits the following brief in opposition to the motion to remand this action to state court filed by plaintiff Freda Sussman:

/ / /

/ / /

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

TABLE OF CONTENTS

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

TABLE OF AUTHORITIES

Federal Cases

State Cases

Federal Statutes

Federal Regulations

State Statutes

Other Treatises

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

I. INTRODUCTION

On November 13, 2007, plaintiff commenced a state court action in San Diego County Superior Court alleging three causes of action against defendant Health Net of California, Inc. ("Health Net"), all arising from an alleged denial of Medicare Act benefits she claims were due her through her membership in the federal Medicare Advantage (MA) program[1/] health plan issued by Health Net, known as "Seniority Plus": (1) "Bad Faith Insurance Tactics"; (2) Fraud and Deceit; and (3) Unfair Business Practices. Plaintiff alleges that she was denied benefits under her Medicare health plan for post-stroke rehabilitation services, had to pay for them herself, and makes claim for reimbursement. Plaintiff further alleges that Health Net made marketing misrepresentations to her and other members of the public that they would receive adequate care, inducing them to rely on Health Net to fulfill its contractual duty to plaintiff. Finally, plaintiff alleges Health Net engaged in unfair business practices in refusing to pay for its members' adequate care, and in causing health care providers to consider their own financial interests paramount by offering them incentives that discourage them from rendering necessary care to plan members. (*Complaint*, ¶¶ 52-73.).

Health Net removed the action to this Court on March 3, 2008. The action presents a federal question, since the Medicare Act as amended completely preempts the three purported state law causes of action plaintiff alleges against Health Net. Plaintiff filed a remand motion, asserting that her allegedly state law claims are not preempted by the Medicare Act, even as amended, and that she need not exhaust her Medicare administrative remedies under federal law before seeking judicial review.

/ / /

[1/]The federal Medicare Advantage program, originally enacted by Congress as the "Medicare + Choice" program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003, § 201 (P.L. 108-173 (Dec. 8,2003), 42 U.S.C. 1395w-21 note)), provides eligible Medicare beneficiaries with the option of receiving their Medicare benefits through enrollment in a Medicare Advantage health plan issued by a private insurer or health care service plan. (42 U.S.C. § 1395w-21(a)(1)(B).)

Although federal question removal jurisdiction in this Court is established, and remand should be denied, the Court should refrain from exercising jurisdiction now on ripeness grounds, and should dismiss plaintiff's claims as requested in Health Net's pending motion for that relief.[2/] That will allow plaintiff to exhaust her administrative remedies, which were most recently broadened by the 2003 amendments to the Medicare Act known as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA").

II. FACTUAL BACKGROUND

According to the complaint, plaintiff was a participant in the Health Net "Seniority Plus" plan, a Medicare Advantage plan administered by Health Net. (*Complaint,* ¶ 53.) On or about February 23, 2007, plaintiff suffered a stroke, and was admitted to the intensive care unit of Alvarado Hospital (Alvarado). (*Complaint,* ¶¶ 19, 54.) Plaintiff claims that, contrary to her MA health plan, Health Net refused her request for medically necessary rehabilitation services for her as part of a pattern and practice of refusing to pay for adequate care for its members in order to increase its profits. (*Complaint,* ¶¶ 58-59.) As a result, plaintiff was forced to incur the more than $51,000 out-of-pocket cost of rehabilitation services and physician bills.

[2/]As detailed at pages 15-17 of its motion to dismiss, Health Net asks the Court to follow such cases as *Dielsi v. Falk*, 916 F.Supp. 985, 994 (C.D. Cal. 1996), by declining to remand based on complete federal pre-emption (there Copyright law), but, exercising its removal jurisdiction, dismissing the action for lack of subject matter jurisdiction. Here, the lack of subject matter jurisdiction is reinforced by plaintiff's failure to exhaust her administrative remedies. As pointed out by the Court in *Dielsi*, pp. 994-995, "federal courts are often presented with removed state claims that are completely preempted by the Employees' Retirement Income Security Act ('ERISA'). In such a case, the federal court will exercise removal jurisdiction. Then, the Court is presented with the question of whether the plaintiff has exhausted his or her administrative remedies. If exhaustion is not futile, a federal court will refrain from exercising jurisdiction on ripeness grounds and *dismiss* the preempted ERISA claim without prejudice. *See, e.g., Franklin H. Williams Ins. Trust v. Travelers Ins. Co.,* 847 F. Supp. 23 (S.D.N.Y. 1994), *rev'd on other grounds,* 50 F.3d 144 (2d Cir. 1995) (accepting removal jurisdiction but then dismissing for failure to exhaust)". (Footnote omitted. Emphasis in original.) As the court did in *Dielsi*, this Court should decline to remand the case to state court as meaningless, since federal courts have exclusive jurisdiction under the Medicare Act to review the ruling emerging from the administrative process.

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

(*Complaint,* ¶¶ 57, 61.) Plaintiff alleges that Health Net's conduct constitutes "bad faith insurance tactics."

Additionally, plaintiff alleges a cause of action against Health Net for fraud and deceit. Plaintiff asserts that Health Net engages in a practice of representing to members of the public that, by enrolling in the Seniority Plus plan, enrollees will receive thoroughly adequate care that is superior to that provided by Medicare. (*Complaint,* ¶ 65.) Plaintiff claims that through the use of incentives and disincentives to providers, Health Net actually discourages the rendering of necessary care to its members. (*Complaint,* ¶ 65.)

Finally, plaintiff alleges that Health Net's marketing of Seniority Plus and its use of combined incentives and disincentives to providers to discourage the rendering of necessary care in order to garner more profits constitute unfair business practices under California Business and Professions Code Section 17200 *et seq.* (*Complaint,* ¶¶ 70, 72-73.)

III. ARGUMENT

A. Overview of Complete Preemption Created by the Medicare Act As Amended

While removal jurisdiction based on a federal question generally requires that question to appear on the face of the complaint:

> "a state claim may be removed to federal court . . . when a federal statute wholly displaces the state-law cause of action through complete preemption. When the federal statute completely preempts the state-law cause of action, a claim which comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law. This claim is then removable under 28 U.S.C. § 1441(b), which authorizes any claim that 'arises under' federal law to be removed to federal court."

(*Beneficial National Bank v. Anderson*, 539 U.S. 1, 8-9 (2003).)

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

When a federal statute provides the exclusive cause of action for the claims asserted by a plaintiff--especially when it sets forth procedures and remedies governing that cause of action--the state law claims will be recharacterized as federal claims under the "complete preemption" doctrine. (*Id.*, p. 9.) As demonstrated below, both of these requirements are met here. The Medicare Act and its regulations expressly supersede "*any State law or regulation*" with respect to MA plans (42 U.S.C. § 1395w-26(b)(3); emphasis added), and the Medicare Act, as amended, sets forth a detailed, and exclusive, administrative scheme for addressing all of plaintiff's state law claims for relief.

B. Plaintiff's "State Law" Claims Are Expressly Pre-Empted By Federal Law

Congress has progressively broadened the sweep of the federal preemption effect of the Medicare Act. Initially, the Medicare Act afforded only limited preemption, vesting in the Secretary of Health and Human Services the exclusive authority to determine what claims are covered by the act, and judicial review of that determination exclusively in federal district courts. (*Heckler v. Ringer*, 466 U.S. 602, 605 [104 S.Ct. 2013, 80 L.Ed.2d 622] (1984).) Then the Medicare Act was amended by the Balanced Budget Act of 1997 (BBA), which established the Medicare + Choice program (now MA) as a new part of Medicare, affording beneficiaries a new range of Medicare managed care options. The BBA modified the Medicare Act to preempt state laws concerning only specific subjects, and otherwise only where the state laws were inconsistent with Medicare. (*McCall v. Pacificare of California, Inc.*, 25 Cal.4th 412, 423 (2001).)

In 2003, the Medicare Act was again amended, this time to outlaw any state law relating to MA plans, period. The complete preemption provision was adopted as part of the MMA:

/ / /

/ / /

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

> Relation to State laws. The standards established under this part shall supersede *any* State law or regulation (other than State licensing laws or State laws relating to plan solvency) *with respect to* MA plans which are offered by MA organizations under this part.

(42 U.S.C. § 1395w-26(b)(3). Emphasis added.) Quoting this preemption provision, Judge Conti of the district court in Northern California, stated:

> "[W]hen Congress has 'unmistakably . . . ordained,' that its enactments alone are to regulate a part of commerce, state laws regulating that aspect of commerce must fall. . . . Here, Congress has unmistakably ordained that Medicare preempts all state regulation. . . ."

(*Drissi v. Kaiser Foundation Hospitals, Inc., supra.*)

This Medicare provision parallels the wording of ERISA,[3/] which expressly and broadly preempts "any and all state laws" that "relate to any employee benefit plan". (*Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139-140 (1990) [ERISA preempts employee's state law claim of wrongful discharge in order to avoid paying pension benefits].)

The Supreme Court recently held that legislative preemption provisions referring to such matters as "state law or regulation" include not only statutes and administrative regulation, but also the states' common-law duties, which here would be implicated by two of plaintiff's three state law claims:

> Absent other indication, reference to a State's "requirements" includes its common-law duties. . . . [C]ommon law liability is "premised on the existence of a legal duty," and a tort judgment therefore establishes that the defendant has violated a state-law obligation. . . . And while the

---

[3/] "Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 USCS § 1003(a)] and not exempt under section 4(b) [29 USCS § 1003(b)]." (29 U.S.C. § 1144(a).)

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

> common-law remedy is limited to damages, a liability award '"can be, indeed is designed to be, a potent method of governing conduct and controlling policy."' . . . [I]t is implausible that the [Medical Device Amendments of 1976 (MDA)] was meant to 'grant greater power (to set standards "different from, or in addition to" federal standards) to a single state jury than to state officials acting through state administrative or legislative lawmaking processes.' . . . That perverse distinction is not required or even suggested by the broad language Congress chose in the MDA, and we will not turn somersaults to create it."

(*Riegel v. Medtronic, Inc.*, __ U.S. __, 128 S.Ct. 999, 1008-1009 (February 20, 2008), citations and footnotes omitted.)

The legislative history of the preemption provision of the MMA makes clear that it means what it says: "[T]he [Medicare Advantage Program] is a federal program operated under Federal rules and that State laws, [sic] do not, and should not apply, with the exception of state licensing laws or state laws related to plan solvency." (H. Conf. Rep. 108-391 at 557, as quoted in *First Medical Health Plan, Inc. v. Vega-Ramos*, 479 F.3d 46, 51 (1st Cir. 2007).)

The Code of Federal Regulations explains that the scope of Part 422 "establishes standards and sets forth the requirements, limitations, and procedures for Medicare services furnished, or paid for, by Medicare Advantage organizations through Medicare Advantage plans." (42 C.F.R. Ch. IV, Subch B, Part 422, Medicare Advantage Program, 42 C.F.R. § 422.1.) Under these standards, when a member is unhappy about the denial of benefits, she first appeals to the plan, then to an administrative law judge. Either party dissatisfied with the ruling of the administrative law judge can appeal to the Secretary of Health and Human Services. If either party is dissatisfied with that ruling, he, she or it may seek judicial review in the United States District Court. (42 U.S.C. §§ 405(g); 1395w-22(g)(5); 42 C.F.R. Part 422, Subpart M. § 422.560, et seq.)

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

Additional standards regulate the remaining matters at issue in plaintiff's complaint. Marketing materials and election forms used by MA plans are regulated by 42 C.F.R. § 422.80. "Marketing materials" are defined as including "any informational materials targeted to Medicare beneficiaries" which promote the Medicare Advantage plan, inform Medicare beneficiaries about enrollment, explain the benefits of enrollment, or explain how Medicare services are covered under the Medicare Advantage plan. (42 C.F.R. § 422.80(b)(1)-(4).) If an enrollee believes that a Medicare Advantage plan is marketing its product in violation of these regulations, he or she can file a grievance and participate in a multi-step grievance procedure with CMS. (42 C.F.R. § 422.564.)

Thus, the Medicare Act expressly and completely preempts plaintiff's causes of action against Health Net. Her complaints about benefits must be addressed through the administrative process described at 42 U.S.C. § 1395w-22(g) and her complaints about marketing representations must be addressed through the administrative process described at 42 C.F.R. § 422.564.[4/]

C. The Medicare Act, as Amended, Sets Forth a Detailed, and Exclusive, Administrative and Post-Exhaustion Judicial Review Scheme Addressing All of Plaintiff's State Law Claims for Relief.

In *Heckler v. Ringer*, *supra*, the United States Supreme Court held that a claim which "arises under" the Medicare Act must first be brought before the Secretary through a multilevel administrative review process. (*Id.* at 615.) This administrative review process (which is also expressly set forth in the contract between plaintiff and

---

[4/]Plaintiff cites *County of Pierce v. Leavitt*, 244 Fed.Appx. 802 (9th Cir. 2007) for the proposition that the Medicare Act specifically precludes federal question jurisdiction under 28 U.S.C. section 1331. However, *Leavitt* specifically states that "§ 405(g) [of the Medicare Act] is the exclusive means of judicial review of the Secretary's decisions in Medicare cases. Therefore, unless the requirements of § 405(g) would lead to complete preclusion of review, a party bringing suit under the Medicare statute may only do so pursuant to § 405(g)." (*Id.* at 803.) As described above, section 405(g) provides for review of the Secretary's decision in the district court, upon exhaustion of the remedial process set forth therein.

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

Health Net) provides the exclusive remedy for such claims. Judicial review of such claims is available only after the claimant has pressed the claim through every level of the administrative review process to a "final" decision by the Secretary and even then such review may only be obtained in *federal* court. (*Id.* at 605; *see also* 42 U.S.C. §§ 405(g), 1394w-22(g)(5).)

1. Plaintiff's claim of entitlement to MA benefits is preempted.

In her complaint, plaintiff has combined both her claim of entitlement to benefits and allegations of bad faith conduct into one cause of action labeled "bad faith insurance tactics." Plaintiff alleges that Health Net failed to approve and pay for rehabilitation services - clearly health care services - and that Health Net did so in bad faith. Because plaintiff's benefit claims "arise under" Medicare, her cause of action for bad faith failure to pay for services is barred by the exclusive review provisions of the Medicare Act.

In the seminal decision in this area, *Heckler v. Ringer*, *supra*, the United States Supreme Court held that a claim arises under Medicare if (1) both the standing and the substantive basis for the presentation of the claim is the Medicare Act (*Id.* at 615), or (2) the claim is "inextricably intertwined" with a claim for Medicare benefits. (*Id.* at 614.) A claim that is "wholly collateral" to a claim for benefits under the Medicare Act is not subject to the exclusive review provisions of the Act.

In *Ringer*, the plaintiffs were four Medicare beneficiaries who suffered from respiratory distress; three had undergone bilateral carotid body resection (BCBR) surgery and were seeking reimbursement of the cost of the procedure, and one sought to have the BCBR surgery but could not afford it unless the procedure was covered by Medicare. (*Id.* at 609-610.) The Secretary of Health and Human Services had ruled that Medicare did not cover the procedure when performed to relieve respiratory distress because the procedure was not generally accepted in the professional medical community and was, therefore, not reasonable and necessary within the meaning of Medicare. (*Id.* at 607.) Plaintiffs filed a complaint in federal district court seeking

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

both declaratory and injunctive relief. The district court dismissed the action for lack of jurisdiction concluding that the essence of plaintiffs' claim was one of entitlement to benefits for the BCBR procedure and that plaintiffs were required to exhaust administrative remedies before seeking relief in federal court. (*Id.* at 610-611.) The Court of Appeals reversed the decision concluding that exhaustion would be futile and might not fully compensate plaintiffs for their injuries. (*Id.* at 612.) The Supreme Court held that the Medicare beneficiaries in *Ringer,* at bottom, sought Medicare reimbursement or authorization for a particular surgical procedure. Thus, the Court had no difficulty concluding that both the standing and substantive basis of the claims was the Medicare Act, that the claims, therefore, were ones "arising under" Medicare, and that "all aspects of of respondents' claims for benefits should be channeled first into the administrative process which Congress has provided for the determination of claims for benefits." (*Id.* at 614.)

Even before enactment of the 2003 complete pre-emption provision for MA program health plans, cases decided after *Ringer* have interpreted the "arising under" language to mean that claims that are, at bottom, claims for reimbursements of benefits are "inextricably intertwined" with a claim for benefits and, therefore, arise under the Medicare Act. *(See, e.g., Ardary v. Aetna Health Plans of Calif., Inc.,* 98 F.3d 496, 500 (9th Cir. 1996).) In *Ardary*, the Court of Appeals held that an action for compensatory and punitive damages brought by the heirs of a deceased Medicare beneficiary for a private Medicare provider's failure to authorize an airlift to a larger hospital resulting in the beneficiary's death was not preempted by the Medicare Act. The Court found that the claims were not, at bottom, seeking to recover benefits as a beneficiary's death could not be remedied by the retroactive authorization or payment of the airlift transfer. (*Id.* at 500.)

/ / /

/ / /

/ / /

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

However, in *Hooker v. United States Department of Health and Human Services,* 858 F.2d 525 (9th Cir. 1988), the Ninth Circuit rejected plaintiffs' state law claims arising out of the Social Security Administration's allegedly wrongful termination of disability benefits. There, Laurence Hooker committed suicide after he was denied further disability benefits. Among other things, his heirs sued two state employees for negligence. The district court dismissed the action, holding that 42 U.S.C. Section 405 barred plaintiffs' state law claim for negligence, since it was "merely a disguised dispute with the Secretary." (*Id.* at 529.) The Ninth Circuit affirmed, holding that claims for damages arising out of the Secretary's acts "arise under" the Medicare Act. (*Id.*) The Court specifically cited to the six-step administrative process that controls this dispute. (*See also, Jenkins v. Social Security Administration,* 42 Fed. Appx. 995 (9th Cir. 2002) [plaintiff could not circumvent exhaustion requirement of 42 U.S.C. § 405(h) by characterizing his action as one for civil rights violations].)

Here, just as three of the plaintiffs in *Ringer*, plaintiff explicitly seeks reimbursement for medical services she claims should have been provided her, and that she paid for as a result of Health Net's denial of her request for authorization. (*Complaint*, ¶¶ 57 and 61.) Plaintiff's claim for reimbursement of her out-of-pocket expenses may be addressed by the retroactive payment of the disputed benefits. Just as in *Ringer*, too, where the plaintiffs challenged the determination that the medical procedure in issue was not "reasonable and necessary" under the Medicare Act (466 U.S. at p. 607), so plaintiff here challenges the medical basis of Health Net's decision not to provide her with rehabilitation therapy (*Complaint*, ¶ 58), and seeks reimbursement of the cost of such therapy (*Complaint*, ¶ 61). Accordingly, her sole remedy is that set forth in the Medicare Act. As explained in *Ringer*, because Congress has vested in the Secretary the exclusive power to administer the Medicare system, any state court damage award that is logically dependent on a finding of a wrongful denial of benefits is "inextricably intertwined" with a Medicare claim.

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

(*Ringer, supra* at 614.) Plaintiff's claims are "inextricably intertwined" with a claim for Medicare benefits and, therefore, arise under the Medicare Act.

2. Plaintiff's "bad faith" claim is preempted.

To the extent this claim is for "bad faith" or breach of the implied covenant, instead of for breach of contract, it, too, is preempted. While Health Net operates a health care service plan and not an insurer, analogizing to insurance law demonstrates that this cause of action must fail, as a matter of law. It has long been established that a "bad faith" cause of action is "on the contract." (*See, e.g., 20th Century Ins. Co. v. Superior Court,* 90 Cal.App.4th 1247, 1280 (2001); *Prieto v. State Farm Fire & Casualty Co.,* 225 Cal.App.3d 1188, 1193 (1990).) This is because an insurer can be liable for breach of the implied covenant of good faith and fair dealing only if it unreasonably withholds benefits due under the policy. (*Waller v. Truck Ins. Exchange, Inc.,* 11 Cal.4th 1, 35 (1995); *Love v. Fire Ins. Exchange,* 221 Cal.App. 3d 1136, 1151 (1990).) If no benefits are due under the policy, a bad faith claim is barred as a matter of law. (*Brodkin v. State Farm Fire & Casualty Co.,* 217 Cal.App.3d 210, 218 (1989); *Ray v. Farmers Ins. Exchange,* 200 Cal.App.3d 1411, 1418, fn. 4 (1988).)

Thus, a necessary predicate to any "bad faith" cause of action is a determination by the Secretary that there was a breach of contract; i.e., that plaintiff is entitled to rehabilitation services benefits that she did not receive. Since only the Secretary can make that determination, this cause of action is not yet ripe.

3. Plaintiff's Fraud And Deceit claim is preempted by the Medicare Act

Plaintiff alleges in her fraud and deceit cause of action that Health Net engages in a practice of representing to members of the public that, by enrolling in the Seniority Plus plan, enrollees will receive thoroughly adequate care that is superior to that provided by Medicare. (*Complaint,* ¶ 65.) Plaintiff claims, however, that Health Net, through the use of incentives and disincentives to health care providers, actually

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

discourages the rendering of necessary care to its members. (*Complaint,* ¶ 65.) As a result, plaintiff claims she relied on Health Net's marketing misrepresentations, enrolled in the health plan and received substandard care. (*Complaint,* ¶ 68.)

The MMA regulations squarely preempt this cause of action. Section 422.80 of the Code of Federal Regulations regulates marketing materials, including any informational materials targeted to Medicare beneficiaries which promote the Medicare Advantage plan, inform Medicare beneficiaries about enrollment, explain the benefits of enrollment, or explain how Medicare services are covered under the Medicare Advantage plan, and provide an exclusive remedy for complaints arising out of that marketing material. (42 C.F.R. § 422.80(b)(1)-(4).)

In *Dial v. Healthspring of Ala., Inc.*, 501 F.Supp.2d 1348 (S.D. Ala. 2007) [on appeal to the 11th Circuit], plaintiffs claimed that agents of a Medicare Advantage plan fraudulently induced them to join the plan by misrepresenting plan benefits. They sued the plan for breach of contract, fraud, negligence and other torts. The plan removed the action, and plaintiffs moved to remand. Plaintiffs argued that they were seeking relief under state law only, and the preemption provision applies only to preclude a state's attempt to establish standards relating to or regulating Medicare Advantage plans. They also argued that their claims were not related to marketing, enrollment, benefit and coverage, and grievance procedures. The plan argued that the standards relating to the marketing of the plan and benefits disputes fell solely under federal law, so removal was proper. The district court found that:

> [P]laintiffs' causes of action based upon defendants' meeting with the plaintiffs, soliciting their enrollment, and making representations as to the quality and scope of benefits and coverage, and as to plaintiffs' ability to continue treatment with their doctors and hospitals, fall within areas which Congress intended to regulate through the MMA, and thus are preempted by federal law.

(*Id.* at 1359.)

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

Dial relied, in part, on *First Medical Health Plan, Inc. v. Vega-Ramos*, *supra*, which stated in dictum, "Congress' purpose in enacting § 1395w-26(b)(3) was to protect the purely federal nature of Medicare Advantage plans operating under Medicare...." (*Id.* at 51-52.)

Two cases from the Northern District of California have agreed that the MMA completely pre-empts matters relating to the marketing process underlying plaintiff's fraud claim. In *Clay v. Permanente Medical Group, Inc.*, 2007 WL 4374273 (N.D. Cal. 2007), plaintiff alleged nine causes of action against Kaiser related to the alleged mishandling of a kidney transplant. Kaiser removed the case, alleging jurisdiction pursuant to the Medicare Act, and moved to compel arbitration. The court granted the motion to compel arbitration over the objection that the arbitration clause of the MA plan and enrollment form did not satisfy prominent display requirements of a California statute, Health & Safety Code § 1363.1. Holding that the enrollment form and evidence of coverage were "marketing materials," as that term is defined in 42 C.F.R. Section 422.80(b), subject to CMS regulation, the court held that the Medicare Act preempted application of the state statute to litigation claims based on the marketing or sale of MA plans – the basis of plaintiff's fraud and deceit claim here. (*See also, Drissi v. Kaiser Foundation Hospitals, Inc.*, 2008 WL 54382 (N.D. Cal. 2007) [same holding].)

Plaintiff relies on *McCall v. Pacificare of California, Inc.*, 25 Cal.4th 412 (2001) and *Zolezzi v. Pacificare of California, Inc.*, 105 Cal.App.4th 573 (2003) for the proposition that both her fraud and unfair business practices causes of action are not preempted by Medicare. However, both *McCall* and *Zolezzi* were decided before the most recent amendment to Medicare, the MMA, which not only expressly and completely preempted any state law or regulation with respect to MA plans, but also established new standards relating to the regulation of marketing materials and enrollment forms used by MA plans. (42 C.F.R. § 422.80.) If an enrollee believes that a Medicare Advantage plan is marketing its product in violation of these

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

regulations, he or she can file a grievance and participate in a multi-step grievance procedure with CMS. (42 C.F.R. § 422.564.) Plaintiff's state court fraud claim alleges the improper marketing of Health Net's Medicare Advantage product, and it is therefore preempted, and plaintiffs may only seek judicial review in federal court of the Secretary's decision once the administrative process has been exhausted.

Plaintiff also relies on two district court cases out of Alabama and Florida in claiming that the MMA does not preempt plaintiff's causes of action. (*Lassiter v. Pacificare Life & Health Ins. Co.*, 2007 U.S. Dist. LEXIS 91970 (Dist. Ala. 2007); *Masey v. Humana, Inc.*, 2007 U.S. Dist. LEXIS 63556 (Dist. Fla. 2007).) Plaintiff, however, misinterprets the *Masey* court's ruling. In *Masey,* plaintiff alleged that Humana improperly categorized her chemotherapy drugs as being covered under Medicare Part D, but that they should have been paid pursuant to Medicare Part B. The Court held that "because Plaintiff's contract claims are inextricably intertwined with a claim of benefits under the Medicare Act, the requirements of presentment and exhaustion must be met prior to the exercise of judicial review." (*Masey, supra* at *24-25.)[5/] Thus, the holding in *Masey* actually supports Health Net's argument that Sussman's causes of action are preempted.

The *Lassiter* opinion is part of the split of authority that currently exists in the 11th Circuit with respect to Medicare preemption. The split in authority will be addressed through review of the *Dial* decision, which is currently pending before the 11th Circuit Court of Appeals. (*Dial v. Healthspring of Ala., Inc., supra.*) However,

---

[5/] With respect to plaintiff's claim under Kentucky's consumer protection law, it differs from California's unfair business practices statute in Kentucky's law permits the recovery of punitive damages (*Id.* at *28), while in California, only injunctive relief and disgorgement are available. (*See, Dean Witter Reynolds, Inc. v. Superior Court*, 211 Cal.App.3d 758, 774 (1989) [a plaintiff can only recover the equitable remedy of restitution, not compensatory damages, in an unfair competition claim pursuant to Business & Professions Code section 17200 *et seq.*]; *see also Indus. Indemnity Co. v. Superior Court*, 209 Cal.App.3d 1093, 1096 (1989) [a private litigant is allowed only injunctive relief and not damages under the unfair competition laws].) The services have been rendered so an injunction is moot. Plaintiff is also not entitled to disgorgement of her premium payment (if, indeed, she made one) because she admits she received services under her plan.

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

the Ninth Circuit concludes that the MMA completely preempts all state court causes of action concerning Medicare benefits and the marketing of Medicare Advantage health plans. (*See Clay v. Permanente Medical Group, Inc.*, *supra*; *Drissi v. Kaiser Foundation Hospitals, Inc.*, *supra*.)

4. Plaintiff's Unfair Business Practices claim is preempted by the Medicare Act

Plaintiff's unfair business practices claim is preempted for the same reason as her fraud and deceit claim. Plaintiff alleges that Health Net's misleading marketing and its use of combined incentives and disincentives to providers to discourage the rendering of necessary care in order to garner more profits constitutes an unfair business practice within the meaning of California Business and Professions Code Section 17200 *et seq.* (*Complaint,* ¶¶ 71-73.) Specifically, plaintiff avers that Health Net discouraged the use of physical therapy for good candidates such as the plaintiff and rather attempted to send her to a nursing home as a purportedly less expensive alternative. (*Complaint,* ¶ 72.) These allegations concern both the alleged wrongful denial of benefits to plaintiff, and the purported improper marketing of Health Net's Medicare Advantage product to the public at large. As discussed above, such claims are preempted by the Medicare Act and the MMA and, therefore, plaintiff's unfair business practices claim is also subject to preemption.

/ / /

/ / /

/ / /

/ / /

/ / /

/ / /

/ / /

/ / /

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

IV. CONCLUSION

For the foregoing reasons, defendant Health Net respectfully requests that the Court deny plaintiff's motion to remand the action to state court in its entirety based on the grounds stated herein.

DATED: April 7, 2008

Respectfully submitted,

LEWIS BRISBOIS BISGAARD & SMITH LLP

By: /s/ KRISTIN P. KYLE de BAUTISTA
RICHARD B. WOLF
ELISE D. KLEIN
JANELLE F. GARCHIE
KRISTIN P. KYLE de BAUTISTA
Attorneys for Defendant Health Net of California, Inc.
E-Mail: kyledebautista@lbbslaw.com

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800

FEDERAL COURT CERTIFICATE OF SERVICE
Fred Sussman v. Armelia Sani, M.D., et al. - Case No. 08 CV 0392 H BLM

UNITED STATES DISTRICT COURT
SAN DIEGO FEDERAL COURT - SOUTHERN DISTRICT OF CALIFORNIA

At the time of service, I was over 18 years of age and not a party to the action. My business address is 221 North Figueroa Street, Suite 1200, Los Angeles, California 90012. I am employed in the office of a member of the bar of this Court at whose direction the service was made.

On April 7, 2008, I served the following document(s): DEFENDANT HEALTH NET OF CALIFORNIA, INC.'S OPPOSITION TO PLAINTIFF'S MOTION TO REMAND CASE TO STATE COURT

I served the documents on the following persons at the following addresses (including fax numbers and e-mail addresses registered with the Court, if applicable):

Nancy Sussman, Esq.
HAYWORTH & SUSSMAN
1901 First Avenue, Suite 220
San Diego, CA 92101
Tel: (619) 231-1215
Attorneys for Plaintiff, *FREDA SUSSMAN*

Thor O. Emblem, Esq.
LAW OFFICES OF THOR EMBLEM
205 West Fifth Avenue, Suite 105
Escondido, CA 92025
Tel: (760) 738-9301
Attorneys for Plaintiff, *FREDA SUSSMAN*

Lisa Iulianelli, Esq.
CARROLL, KELLY, TROTTER, FRANZEN & McKENNA
P. O. Box 22636
Long Beach, CA 90801-5636
Attorneys for Defendants,*ARMELIA SANI, M.D., SHILEY EYE CENTER UCSD MEDICAL CENTER, REGENTS OF THE UNIVERSITY OF CALIFORNIA, LINDA BEACH, HAIDEE GUTIERREZ*

The documents were served by the following means:

[X] (BY U.S. MAIL) I enclosed the documents in a sealed envelope or package addressed to the persons at the addresses listed above and I placed the envelope or package for collection and mailing, following our ordinary business practices. I am readily familiar with the firm's practice for collection and processing correspondence for mailing. Under that practice, on the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U.S. Postal Service, in a sealed envelope of package with the postage fully prepaid..

[X] (BY COURT'S CM/ECF SYSTEM) Pursuant to Local Rule, I electronically filed the documents with the Clerk of the Court using the CM/ECF system, which sent notification of that filing to the persons listed above.

I declare under penalty of perjury under the laws of the United States of America that the above is true and correct.

Executed on April 7, 2008, at Los Angeles, California.

Rosa Reza

LEWIS BRISBOIS BISGAARD & SMITH LLP
221 NORTH FIGUEROA STREET, SUITE 1200
LOS ANGELES, CALIFORNIA 90012-2601
TELEPHONE (213) 250-1800